STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RITTENHOUSE VILLAGE AT PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00437975. Complaint IN00437975 - State deficiencies related to the allegations are cited at R0052 and R0217. Survey date: 7/18/24 Facility number: 012396 Residential Census: 78 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	The following is the plan of correction for the Rittenhouse Village at Portage in regards to the statement of deficiencies dated July 17th, 2024. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on observation, interview, and record review, the facility failed to prevent resident to resident sexual abuse despite known sexual behaviors for 2 of 2 Memory Care Residents reviewed for abuse. (Residents B & C). Using the reasonable person concept, it is likely this	R 0052	**1.What corrective actions will be accomplished for those residents found to have been affected by deficient practice?** The resident's charts will be reviewed and a plan will be	09/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	deficient practice would lead to chronic anxiety, depressive episodes, or fear. Finding includes: An Indiana Department of Health (IDOH) reported incident, dated 7/1/24, indicated at 2:30 p.m. Resident B was observed by RN 3 in the common living room with her shirt up and her breasts out. Resident C had his mouth on Resident B's breast. During an interview on 7/18/24 at 8:51 a.m., the Memory Care Unit Director indicated Resident B and Resident C were being monitored more closely after an incident of a sexual nature. The residents had a history of talking to each other and holding hands and were always separated and activity diversions were provided. She indicated there was no sexual or inappropriate behaviors prior to 7/1/24. During an observation on 7/18/24 at 8:55 a.m., Resident B was observed sitting in a wheelchair in the Memory Care Unit common room. She was unable to respond appropriately to the conversation. During an interview on 7/18/24 at 9:04 a.m., QMA 1 indicated Resident B thought the male residents were her husband. If a male resident did not show her attention, she would propel her wheelchair toward another male resident. QMA 1 indicated Resident B really liked Resident C. The incident on 7/1/24 was the first time Resident C had made any inappropriate sexual gestures. During an interview on 7/18/24 at 10 a.m., CNA 2 indicated Resident C had been friendly with Resident B in the past, but had made no physical contact.		initiated for socialization to ensure resident rights are maintained and no sexual abuse to continue from resident to resident. Continued partnership with Psych services will also be in place to ensure resident behaviors are maintained. There will be behavior logs implemented to track daily observations of resident's behaviors this will be reviewed weekly by Memory Care Director to ensure appropriate interventions are in place and effective. This will be discussed monthly during QA meetings for a minimum of 6 months. 2.How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All resident charts and nursing notes will be reviewed to identify if any other occurrences took place with any other residents to ensure residents care needs are met and resident rights are maintained. Daily behavior log sheets available for residents who demonstrate any behaviors. 3. What measures will be put into place or what systematic changes the facility will ensure that the deficient practice does not occur? DON or Administrator will reeducate the nurse on resident rights, and reporting incidents	

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	Resident C was observed on 7/18/24 at 10:14 a.m. ambulating with a walker and stand by assistance of the staff from his apartment to the dining room. He was observed at 10:20 a.m. independently ambulating out of the dining room with his walker back to his apartment. A) Resident B's record was reviewed on 7/18/24 at 10:12 a.m. The diagnoses included, but were not limited to, dementia. A Nurse's Progress Note written by RN 3, dated 6/4/24 at 4 p.m., indicated there were ongoing romantic episodes between Resident B and Resident C. The nurse had witnessed full lip contact, "in a sexual way" with Resident C. The Progress Note indicated there were sexual discussions from Resident C, and Resident B had verbalized she wanted Resident C. The nurse had instructed staff on many occasions to separate the residents. Resident B would propel her wheelchair and pursue Resident C. Resident B would seek attention from other male residents if Resident C was not available. Resident B's affections were not met with acceptance by the other male residents. A Nurse's Progress Note, dated 7/1/24 at 1:45 p.m., indicated Resident B was observed in the TV room and Resident C was bent over the resident and held her shirt up and had his mouth on her breast. There were no signs of distress. A Nurse's Progress Note, dated 7/1/24 at 4 p.m., indicated Resident B and Resident C were found kissing. The nurse separated the residents. There were no further Nurse's Progress Notes.		properly. And continued monthly in services will take place for all staff to ensure. There will be Behavior log implemented to track daily observations of any resident inappropriate behaviors. QA meetings will discuss resident behaviors. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur, what quality assurance programs place? DON or Administrator will audit 5 random charts and nursing notes weekly to ensure they are accurate and up to date with any change or care/condition along with a signature by POA. Once weekly chart audit shows full compliance for 4 consecutive weeks audit will continue monthly for minimum of 6 months. There will be a Behavior log implemented to track daily observations of resident's behaviors and this will be reviewed weekly by Memory Care Director to ensure appropriate interventions are in place and effective. This will be discussed monthly during QA meetings and psychiatric services will continue to come in 3 times a month to monitor residents needs.	

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	There were no Behavior Sheets that indicated the resident had inappropriate sexual behaviors. A Service Plan, dated 7/1/24, indicated the resident was confused, had non-intrusive wandering, used a wheelchair for independent mobility, and had no sexually inappropriate behaviors. B) Resident C's record was reviewed on 7/18/24 at 10:36 a.m. The diagnoses included, but were not limited to, dementia. A Behavior Sheet, dated 6/2/24, no time documented, indicated Resident C was holding Resident B's hands. Resident B was removed from the area. A Behavior Sheet, dated 6/2/24, no time documented, indicated a sexual behavior. A female resident (Memory Care Resident B) had made a statement she doesn't want to be alone and kept asking Resident C to sit with her. Resident C then kissed the female resident on the forehead and asked, if she wanted him to "put it in". Resident B was unable to hear him or understand and he repeated the comment again. Resident B was still had not understood so Resident C asked if she wanted him to "put his d*** in". The staff overheard the conversation and separated the residents and explained to Resident C that he was inappropriate and that Resident B was married. Resident C stated he still had a sex drive. The area on the behavior form for potential strategy to control the stimuli was left blank. A Nurse's Progress Note written by RN 3, dated 6/4/24 at 4 p.m., indicated there had been ongoing romantic relations with another resident (Resident			

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	B), who was married. There was full lip kissing between Resident C and Resident B. Resident C was overheard telling Resident B he knew she was married and he did not want to get caught by her husband. He was overheard by staff asking Resident B if she wanted him to "put it in her" and if she wanted him in her "p****". Memory Care Resident B answered with a yes. The staff intervened and separated the residents. A Behavior Sheet, dated 6/5/24, no time documented, indicated Resident C was sitting by Resident B and was watching her. Resident C was redirected and Resident B was removed from the area. A Behavior Sheet, dated 6/6/24, time documented as approximately 3:30 p.m., indicated Resident C was yelling and threatening bodily harm to other residents and staff. He was cursing because he was redirected from touching a resident (Resident B). A Service Plan, dated 6/10/24, indicated there was confusion and disorientation. Resident C wandered intrusively but was easily directed, and there were no agitated or sexually inappropriate behaviors. He used a walker for ambulation and required reminders to us the walker. A Psychiatric Progress Note, dated 6/17/24 at 3:03 p.m., indicated an increase in sertraline (antidepressant) from 50 milligrams (mg) to 150 mg on 6/3/24 due to inappropriate sexual behavior. Resident C was oriented to person and place with moderately impaired judgement and insight. The inappropriate sexual behavior was stable. A Behavior Sheet, dated 7/1/24 at 1:45 p.m., indicated Resident C was found with his mouth on			

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	Resident B's bare breast. The residents were separated. A Nurse's Progress Note, dated 7/1/24 at 1:45 p.m., indicated Resident C was in the TV Room bent over a female resident's wheelchair (Resident B) and had his mouth on her breast. The female resident did not appear to have any distress. The residents were separated. There was no physical harm by either resident. A Nurse's Progress Note, dated 7/1/24 at 4 p.m., indicated Resident B and Resident C were observed kissing. The residents were separated. A Psychiatric Progress Note, dated 7/1/24 at 8:41 p.m., indicated a moderately impaired cognitive status and judgement and insight were fair. The inappropriate sexual behavior was stable. A Nurse's Progress Note, dated 7/4/24 at 5:30 p.m.., indicated Resident C was agitated towards staff due to the staff intervening with his attempts to kiss Resident B. During an interview on 7/18/24 at 11:08 a.m., the Memory Care Unit Director indicated she had only been told that Resident C kissed Resident B on the cheeks. She indicated one CNA (no name given) had informed her that Resident C kissed Resident B on the lips. She was unaware of the other behaviors from Resident C. She was aware there was an attraction between Residents B and C and the staff were trying to keep them separated. After the incident on 7/1/24, staff had been educated that they must stay in the room if Resident B and C were in the same room. No other interventions were identified. During an interview with CNA 4 on 7/18/24 at			

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	11:21 a.m., she indicated she had worked on 7/1/24 and was in the kitchen area when she heard someone say Resident C was acting inappropriately. After the incident, the staff were to remain in the common room if Residents B and C were both in the room. She indicated Resident B would go up to Resident C and grab him and he would take her hand and want to kiss it. CNA 4 indicated she had never seen Resident C touch Resident B inappropriately. She had seen Resident C kiss Resident B on the cheek and staff would intervene and separate them. During an interview with the Director of Nursing (DON) on 7/18/24 at 11:45 a.m., she indicated she was unaware of the inappropriate incidents prior to 7/1/24. She had never been informed and if she would have been informed , she would have reported the incidents to the IDOH and put interventions into place. The facility had a service plan meeting with Resident B's husband and he was aware of Resident's B and C kissing because he had caught them once. During an interview with the Administrator on 7/18/24 at 12 p.m., she indicated she was unaware of the incidents prior to the 7/1/24 reported incident. During an interview on 7/18/24 at 1:21 p.m., RN 3 indicated she had reported the incident on June 4, 2024 to the other nurses and could not recall if she reported the incident to the DON. She stated, "everyone in the whole building knew about it." The undated facility abuse policy, received as current from the Administrator on 7/18/24 at 11:32 a.m., indicated the administrator or designee was responsible for initiating proper interventions to assure the resident was protected from any further			

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	acts of abuse. Any employee who has actual knowledge of abuse or neglect was to immediately submit a complaint to the Administrator. It was the nurses' responsibility to notify the administrator or designee of the allegation as soon as possible. This citation relates to Complaint IN00437975.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure residents' service plans were updated and revised related to sexual behaviors for 2 of 2 residents reviewed for service plans. (Residents B and C) See R0052 for additional information regarding Residents B and C. Findings include: 1. Memory Care Resident B's record was reviewed on 7/18/24 at 10:12 a.m. The diagnoses included, but were not limited to, dementia. The Nurses' Progress Notes, dated 6/4/24/ at 4 p.m., 7/1/24 at 1:45 p.m., and 7/1/24 at 4 p.m., indicated sexual oriented behaviors. Cross reference 0052. A Service Plan, dated 7/1/24, indicated the resident was confused, had non-intrusive wandering, used a wheelchair for independent mobility, and had no sexually inappropriate behaviors. 2. Memory Care Resident C's record was	R 0217	**1.What corrective actions will be accomplished for those residents found to have been affected by deficient practice?** The resident's affected will have their service plan updated with the correct information and signed by resident and/or POA. 2.How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? DON or designee will audit all Memory Care resident service plans to ensure they are all updated and signed by POA. 3. What measures will be put into place or what systematic the facility will ensure that the deficient practice does not occur? DON or designee will review service plans monthly to ensure any residents change in care/condition was documented	09/01/2024

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	reviewed on 7/18/24 at 10:36 a.m. The diagnoses included, but were not limited to, dementia. The Behavior Sheets, dated 6/2/24, 6/4/24, 6/5/24, 6/6/24 and 7/1/24, indicated sexual behaviors towards a female resident. The Nurses' Progress Notes, dated 6/4/24, 7/1/24 at 1:45 p.m. and 7/1/24 at 4 p.m., indicated sexual behaviors towards a female resident. Cross reference R0052. A Service Plan, dated 6/10/24 indicated there was confusion and disorientation. Resident C wandered intrusively, but was easily directed and there were no agitated or sexually inappropriate behaviors. He used a walker for ambulation and required reminders to us the walker. During an interview on 7/18/24 at 11:08 a.m., the Memory Care Unit Director indicated the Director of Nursing (DON) was responsible for updating the service plans. During an interview on 7/18/24 at 11:45 a.m., the DON indicated she was unaware of the inappropriate incidents and she reviewed the residents' records prior to completing service plan updates. The service plan had not been updated regarding the behaviors or any planned interventions. This citation relates to Complaint IN00437975.		on service plan and signed by resident and/or POA. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur, what quality assurance programs place? ED or will audit 5 random service/care plans, weekly for to ensure they are accurate and up to date with any change or care/condition along with a signature by and/or POA. Once weekly audit shows full compliance for 4 consecutive weeks audit will then continue monthly for a minimum of 6 months.	